YEAR-ROUND GUIDE TO BENEFITS

RETIREE BENEFIT GUIDE 2008

ARLINGTON

Your 2008 Benefit Options

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What's New for 2008?

Annual open enrollment will be held from October 4 - 31, 2007. This section is a summary of new plan offerings and enrollment procedures for the 2008 plan year.

This year we have created a separate section for Pre-65 and Post-65 participants. Each section includes the requirements to continue coverage after December 31, 2007. This guide has been created to assist you with an overview of the 2008 plans, and we encourage you to refer to the guide when you have questions regarding your benefit plans throughout the 2008 plan year.

Split Coverage refers to a situation where a family includes a retiree and spouse and/or children and there is a combination of Pre-65 participant(s) and Post-65 participant(s). If your family has this situation, the Pre-65 participant(s) must elect the Value, Core, Plus or Premium Plans and the Post-65 plan participant(s) must elect the Secure Horizons Medicare Advantage or AARP F, J or K Plan. The United Healthcare Medicare Part D Pharmacy Plan may be elected only when you also enroll in one of the AARP supplement plans.

Health Assessment

Over the past few years this tool has become part of our annual enrollment process. Again this year the City offers an incentive to complete or update your individual Health Assessment and be eligible for a City contribution to either the new Health Savings Account (HSA) component of the Value Plan or to a medical Flexible Spending Account (FSA). It is important that you know the health information you provide is confidential. Results are compiled and wellness programs may be offered to you based on your responses. However, participation in any program offerings of United Healthcare or other health program affiliates is completely voluntary.

The Health Assessment is located on www.myuhc.com. To verify you and your spouse (if enrolled) have completed or updated the Health Assessment, we strongly suggest you print a confirmation of completion for your records.

Confirmation Statements

A confirmation statement will be mailed to you in early December. The statement will summarize your medical/pharmacy, dental and vision enrollment for the 2008 plan year. If you have questions regarding your confirmation statement, please contact Workforce Services prior to December 31, 2007.

Annual Enrollment Deadline

The 2008 annual enrollment period will be October 4 – 31, 2007. All enrollment changes must be received in Workforce Services no later than October 31, 2007, at 5 p.m.

If you experience a life event after open enrollment ends, refer to page 6 of this guide. Based on current IRS regulations, changes require notification and enrollment be completed within 31 days of a life event.

Pre-65 Enrollment Procedure

Participants under 65 will only need to complete a 2008 Enrollment / Change Form if a change in coverage is desired. The Retiree Enrollment / Change Form must be received in Workforce Services no later than October 31, 2007, at 5 p.m. If a change form is not received by this date, your 2008 enrollment will continue in the same plan(s) at the same level you were enrolled for the 2007 plan year.

New Medical Plan Design!

In 2008, we are adding a new medical plan to the benefit line-up. The Value Plan has a higher deductible than the Core or Plus Plans, and therefore qualifies as a high deductible plan under the Internal Revenue Code, allowing the City to offer a Health Savings Account (HSA) as part of this plan design.

The Value Plan offers:

- $1,500/$3,000 deductible
- $5,000/$10,000 out-of-pocket maximum
- The deductible counts toward the out-of-pocket maximum
- Deductibles and out-of-pocket maximums include both pharmacy and medical expenses, which differs from the Core and Plus medical and pharmacy plans
- After the deductible is met, the plan pays 90% and you pay 10% of eligible expenses
- Once the out-of-pocket maximum is met, the plan pays 100% of eligible expenses
- The plan accesses the same UHC network and covers the same services as the Core, Plus and Premium Plans.

Additional details about the plan design are located in the plan comparison section of this guide.

Preventative Care Coverage at 100%

Your enrollment in the Value, Core or Plus Plan in 2008 has the added benefit of coverage at 100% for preventative care services. The services included are based on age and gender specific guidelines established by the U.S. Preventative Services Task Force (USPSTF).

New PPO Low Dental Plan

An additional third dental plan option will be available in 2008. The plan is a Low PPO dental plan option that includes preventive, basic and major services. The annual maximum benefit is lower at $750 per person per calendar year and the cost is also lower than the High PPO dental plan. There is no orthodontic coverage under this plan.

Refer to the dental plan comparison chart on page 15 and the plan summary included in your annual open enrollment packet for additional information.

City Contribution to Health Savings Account (HSA)

The 2008 Value Plan meets the Internal Revenue Code definition of a high deductible health plan. As a result, we will be offering a Health Savings Account as a added option when you enroll in the Value Plan. In addition, to assist retirees in the initial funding of the HSA, the City will make a one-time contribution of $500 based on the following criteria:

- Participant must open an HSA and make a contribution to the account AND
- Retiree or spouse (if enrolled) must complete or update the Health Assessment at www.myuhc.com prior to November 30, 2007.

Definitions:
This section will assist you with terminology used in this guide.
Refer to page 19.

Additional information regarding the HSA is included on page 17 of this guide.

City Contribution to Flexible Spending Account (FSA)

The City will make a contribution of 25% of the deductible to an FSA health account for eligible Pre-65 participants based on the following criteria:

- Enrollment in either the Core or Plus medical plan, AND
- The retiree, spouse or surviving spouse must complete or update the Health Assessment at www.myuhc.com prior to November 30, 2007.

Examples:

➤ Selecting the Core Plan with family coverage, which has a deductible of $2,000, the City will contribute $500 to the FSA account

➤ Selecting Plus Plan retiree only option with a $500 deductible, the City will contribute $125 to the FSA account

Each year United Healthcare provides a report of all participants who have completed/updated the assessment by November 30, 2007. The City then makes a contribution to each eligible participant's FSA account. The funds in the FSA health account may be used to cover out-of-pocket health expenses, deductibles and co-insurance. To be eligible for claim reimbursement, services must be included in the eligible listing provided in IRS Publication 502. (Refer to www.irs.gov.)

What Happens to My Coverage as a Post- 65 Participant?

Effective January 1, 2008, medical and pharmacy coverage in the Value, Core, Plus or Premium Plan will end the last day of the month prior to the month you become age 65. Please refer to the Post-65 enrollment section for available plan options when you become age 65.

Pre-65 Participants:
IMPORTANT NOTICE

If we do not receive a completed Enrollment/Change Form in Workforce Services no later than OCTOBER 31, 2007, at 5 p.m., your 2008 benefit plan enrollment will remain exactly the same as your 2007 enrollment.

Post-65 Enrollment Procedure

Effective January 1, 2008, **all participants age 65 and over who wish to have medical coverage** through the City of Arlington **must** enroll in the Secure Horizons Medicare Advantage Plan or one of the AARP plan options. If you are already enrolled in either the Secure Horizons Plan or the AARP Plan K you will not be required to complete a 2008 enrollment form UNLESS you want to make a change in your coverage.

If you are 65 and over AND are currently enrolled in either the CORE, PLUS or PREMIUM Plan, you must complete a new enrollment form for the 2008 plan year. You may select the Secure Horizons Medicare Complete Plan (includes pharmacy) or one of the AARP Medicare supplement plans for the 2008 plan year. If enrolling in the AARP Plan F, J or K, you are also eligible to enroll in the UHC Medicare Part D Pharmacy Plan. All 2008 enrollments must be received in Workforce Services no later than October 31, 2007, at 5 p.m.

AARP Membership Fees If you enroll in one of the AARP plan offerings, you are required to obtain a membership in AARP. In 2008 the City will again pay the annual fee for your AARP membership. If you receive a billing statement from AARP, please notify Workforce Services immediately.

Medicare Reminder The Centers for Medicare and Medicaid (CMS) allows enrollment in one Medicare Part D Plan. The pharmacy plans offered by both Secure Horizons and United Healthcare are Medicare Part D Plans. Every Medicare eligible participant is required to provide the City with a copy of the front of their Medicare card to ensure accurate Medicare numbers are provided to CMS. Your enrollment with a City sponsored plan must be approved by CMS. If you attempt to enroll in more than one pharmacy plan, CMS will deny your coverage and will provide you notification that your request to be enrolled in the City's pharmacy plan has been denied.

What happens if I do not qualify for Medicare Part A? If you retire with the City of Arlington and are eligible for retiree benefit coverage but do not qualify for free Medicare Part A coverage as a result of your City of Arlington Service, the City will reimburse your cost for Medicare Part A coverage for the retiree only. (Retiree must provide documentation of Medicare Part A ineligibility.)

Eligibility is based on all the following criteria:

- Retiree must enroll and pay for Medicare Part B coverage
- Retiree must enroll in either the Secure Horizons Medicare Advantage Plan or one of the AARP supplement plan options,

AND

- Retiree must provide a copy of the Medicare Part A invoice and proof of payment to the City at least quarterly to receive reimbursement.

Post-65 Enrollment Information

Post-65 Participants Enrolled in the 2007 CORE, PLUS OR PREMIUM PLAN: AARP will mail a personalized kit to the home address of all Post-65 participants with 2007 medical coverage under the Core, Plus or Premium Plan. If you do not receive a packet by October 15, contact the City 817-459-6869. The 2008 Retiree Enrollment / Change Form must be completed and received in Workforce Services no later than October 31, 2007, at 5 p.m. If we do not receive new medical enrollment forms for you, your current medical coverage will end December 31, 2007, at midnight.

NEW MEDICARE ELIGIBILITY: AARP will mail a **personalized kit** to the home address of participants who will be age 65 by January 2008. All other medical plan participants who will be age 65 between February 1 and December 31, 2008, will be provided with plan information for the Secure Horizons and AARP supplement plan options prior to the month they reach age 65. Individuals are responsible for providing a copy of the front of their Medicare card to the City as soon as it is received. The Secure Horizons Medicare Advantage or AARP Plan F, J or K plan coverage will begin the first of the month when enrollment materials are received in Workforce Services prior to the first day of the month in which a participant becomes age 65 **AND** the participant has been enrolled in **both** Medicare Part A and Part B. An Enrollment / Change Form must be completed and returned to the City for processing a coverage change request.

Post-65 Enrollment Changes for 2008 Q & A

Q. I am currently in the Secure Horizons Plan but want to change my enrollment to one of the AARP Plan options being offered by the City for the 2008 plan year. What should I do?

A. You must first contact Secure Horizons and request your coverage with them be terminated effective December 31, 2007 by calling 1-800-950-9355. Then contact the City by calling 817-459-6869 to order an AARP kit. Kits take about 3 weeks to be personalized and delivered. When you receive your kit from AARP (the City's AARP Employer Number is 000682 and should be included in your kit), you will need to complete the application form and mail to AARP immediately. However, you should not delay in completing the City of Arlington Enrollment / Change Form indicating your new plan elections for medical, dental, vision and pharmacy effective 1/1/08. The City's Enrollment / Change Form is due in Workforce Services no later than October 31, 2007 at 5 p.m. **NOTE:** If you decline all pharmacy coverage through the City, you must complete the UnitedHealth Rx "GREEN" Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage

Q I am currently in the AARP Plan K and want to now enroll in the AARP Plan F or J for the 2008 plan year. What should I do?

A. You must contact AARP by calling 1-800-392-7537 and tell them you want to switch from the Plan K to either the Plan F or J effective 1/1/08. You will also need to complete a City of Arlington Enrollment / Change Form indicating your medical, dental, vision and pharmacy elections effective 1/1/08. You should not delay in completing the City of Arlington Enrollment / Change Form indicating your new plan elections for medical, dental, vision and pharmacy effective 1/1/08. The City's Enrollment / Change Form is due in Workforce Services no later than October 31, 2007 at 5 p.m. **NOTE:** If you decline pharmacy coverage through the City, you must complete the UnitedHealth Rx "GREEN" Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage.

Q. I am age 65+ and for the 2007 plan year I am enrolled in the Core, Plus or Premium Plan. What do I need to do to enroll in the Secure Horizons Medicare Complete Plan OR one of the AARP Plans with the United Healthcare Medicare pharmacy plan?

A. To enroll in the Secure Horizons Medicare Complete Plan, you must complete a Secure Horizons enrollment form and mail it to Secure Horizons. A Secure Horizons kit will be available at Open Enrollment meetings.

Or, to enroll in one of the AARP Plans, contact the City by calling 817.459.6869 to order a kit. Kits take about 3 weeks to be personalized and delivered to you. A sample AARP kit has been included in your packet. When you receive your kit from AARP, you will need to complete the application form and mail to AARP immediately. If you want to also enroll in the UHC Medicare Pharmacy Plan, you only need to indicate this on the 2008 Retiree Enrollment / Change Form. You will also need to indicate your medical, dental and vision elections to become effective 1/1/08. You should not delay in completing the City of Arlington Enrollment / Change Form indicating your new plan elections for medical, dental, vision and pharmacy effective 1/1/08. The City's Enrollment / Change Form is due in Workforce Services by October 31, 2007, at 5 p.m. **NOTE:** If you decline pharmacy coverage through the City, you must complete the UnitedHealth Rx "GREEN" Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage.

Q. If I enroll in one of the AARP supplement plans, am I required to also enroll in the UHC Medicare Pharmacy Plan offered through the City?

A. No. In fact we suggest you compare

Post-65 Participants:

If you are currently enrolled in the Core, Plus or Premium Plans, you MUST submit a 2008 Enrollment/Change Form. You have the option to enroll in either the Secure Horizons Medicare Advantage Plan or one of the AARP Medicare Supplement Plans. Retiree coverage may not be continued in the Core, Plus or Premium Plans in 2008.

other Medicare Part D Plans to ensure a plan that fits your needs. However, if you enroll in one of the AARP Plans but want to decline pharmacy coverage, you must complete the UnitedHealth Rx "GREEN" Form to Decline Group Retiree Medicare Prescription Drug Plan Coverage. This form is only required if you do not enroll in a Part D Plan through the City. The Secure Horizons Plan offered through the City includes Medicare Part D pharmacy coverage.

Getting Started

Retiree Eligibility

Retirees who want to enroll in the benefit plans described in this Retiree Benefit Guide must meet the following criteria:

- Retired prior to January 1, 2008
- Eligible for retirement with the Texas Municipal Retirement System (TMRS); and
- Have a minimum 10 years of full-time service with the City of Arlington.

When eligible, you are required to enroll no later than 31 days after your retirement. If enrollment is not completed within this time period, you will have no coverage for the remainder of the plan year for the following plans:

- Medical Plan
- Dental Plan
- Pharmacy Plan
- Vision Plan

Dependent Eligibility

Dependent: the Participant's legal spouse or an unmarried dependent child of the Participant or the Participant's spouse. The term child includes the following: A natural child, stepchild, legally adopted child, a child placed for adoption, or a child for whom legal guardianship has been awarded to participant or participant's spouse. The definition of Dependent is subject to the following conditions and limitations:

- A Dependent includes any unmarried dependent child under the age of 25 based on the following criteria:
- An unmarried dependent child who is 19 years of age, but under the age of 25 years, only if you furnish evidence upon our request, satisfactory to us, of all the following conditions:
  - The child must not be regularly employed on a full time basis.
  - The child must be primarily dependent upon participant for support and maintenance and must be a "qualifying child" based on IRS regulations (refer to IRS publication 501 available at www.irs.gov).
- A dependent also includes a child for whom health care coverage is required through a "Qualified Medical Support Order" or other court or administrative order.

If a dependent becomes ineligible, an Enrollment / Change Form is required within 31 days. The participant must reimburse the City if it is determined a child has become ineligible and the City has paid benefits after the child became ineligible. If you fail to make the change within the required 31 days, your dependent remains ineligible for benefits; however, you may only drop coverage the first of the month after an Enrollment/Change Form is received in Workforce Services.

Surviving Spouse Eligibility

Surviving spouse coverage is available when the spouse is covered by a City plan the day prior to the retiree's death. Dependent children enrolled in coverage under the plan at the time of a retiree's death where there is no spouse coverage, will be provided with COBRA continuation coverage options.

Annual Open Enrollment

- If making a change in your medical, dental and/or vision plan(s), we must receive a Retiree Enrollment / Change Form in Workforce Services no later than October 31, 2007 at 5 p.m.
- A confirmation statement outlining your 2008 benefits enrollment will be mailed to you in early December.
- Participants are responsible for reviewing the confirmation statement and notifying the City of any data entry errors prior to December 31, 2007, at 5 p.m.

New Retiree Enrollment:

- You will receive enrollment information during your retiree exit meeting.
- Review and complete your enrollment within 31 days of retirement.

Enrollment Due Dates

- Annual open enrollment must be completed no later than October 31, 2007, by 5 p.m.
- New retiree enrollment must be completed within 31 days of your retirement.
- If you fail to enroll by the due date, you must wait until the next annual open enrollment period which is held in the last quarter of the calendar year, with coverage effective January 1 of the next plan year. Pre-existing conditions may be excluded.

See *Family Status Change* for special enrollment rights during the year.

The information in this guide is intended to assist with your 2008 benefit enrollment. However, not all plan provisions, limitations, or exclusions are described in this publication. In case of a conflict between the information in this summary and the actual plan documents and insurance contracts, the plan documents and insurance contracts will govern. The City of Arlington reserves the right to change or terminate benefits at any time. Neither the benefits, nor this guide, should be interpreted as a guarantee of future benefits.

Family Status Change: Changing Benefit Elections

Your Special Enrollment Rights Under HIPAA

Retirees may drop or add coverage during the year if the change qualifies under the special enrollment rights as outlined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

You, your spouse, or your children may be entitled to enroll in the medical, dental and vision plans at times other than annual open enrollment. Generally, you may enroll in these plans when:

- Other coverage ends because you or your dependents are no longer eligible;
- You or your dependent exhausts COBRA coverage under another employer's plan;
- You gain a dependent, you marry, have a new child by birth or adoption, or a child is placed with you for adoption; or
- The other employer sponsoring the other coverage is no longer making contributions toward the cost of coverage.

The benefit plan change must be consistent with the reason for the change. Consistent means the change must result in the gain or loss of coverage by you, your spouse, or your dependent children, and the new election must reflect that gain or loss.

A Retiree Enrollment / Change Form must be received in Workforce Services within 31 days of the date of a change. The change will be retroactive to the date of the status change (life event). You are required to notify the City of all changes within a 31 day period, including adding or dropping dependents, even if it will not change your level of coverage or contribution amount.

Declining Coverage or Cancellation of Coverage

Retirees and their eligible dependents may drop medical coverage and re-enter the plan based on the following criteria:

- At any time during the year if the change is qualified as outlined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), or
- During the annual open enrollment period with coverage becoming effective January 1 of the plan year following the annual open enrollment period.

The retiree will be eligible for the City contribution in place at the time of re-enrollment for themselves and their dependents based on their applicable years of service with the City. Retirees must remain on the plan in the same type coverage to allow a spouse or child to enroll. Surviving spouses may continue medical coverage through the City only if they were enrolled in the same type benefit plan at the time of the retiree's death. **NOTE:** Once a participant has dropped coverage and is re-enrolling in the plan, pre-existing conditions may be excluded.

Health Care Benefits - Medical Plans

For 2008, retirees under the age of 65 may choose from four medical plan options. All plans provide in-network benefits only.

All services provided by out-of-network providers and facilities are the responsibility of the participant. Regardless of the plan you enroll in, you are encouraged to choose a primary care physician (PCP) from the United Healthcare network to coordinate your health care, although a PCP is not required. Additionally, a referral is not necessary to see a specialist in the United Healthcare network.

All four plans provide coverage for the same services and include the same provider network. The plans differ in the deductibles and the co-insurance out-of-pocket maximums.

1. Core Plan

(In-Network Providers/Facilities ONLY)

- $1,000 per person, $2,000 per family deductible.
- Deductible must be paid before the plan will pay health benefits.
- After deductible has been met for the plan year, the plan pays co-insurance of 80% and participants are responsible for 20% of eligible expenses.
- The co-insurance applies to all incurred medical plan covered services, whether at the physician's office, the emergency room, out-patient surgery, or hospital admissions.
- The maximum amount of co-insurance that you will pay on this plan is $4,000 per person or $8,000 per family.
- The plan pays preventative care services at 100% and is not subject to the deductible. Preventative services include, but are not limited to well woman visits, well baby visits, immunizations, and annual physicals per USPSTF guidelines.

2. Plus Plan

(In-Network Providers/Facilities ONLY)

- $500 per person, $1,000 per family deductible.
- Deductible must be paid before plan will begin to pay medical benefits.
- After the deductible has been met for the plan year, the plan pays co-insurance of 80% and participants are responsible for 20% of eligible expenses.
- The coinsurance applies to all medical plan covered services incurred, whether at the physician's office, the emergency room, out-patient surgery, or hospital admissions.
- The maximum amount of co-insurance that you will pay on this plan is $2,500 per person or $5,000 per family.
- The plan pays preventative care services at 100% and is not subject to the deductible. Preventative services include, but are not limited to well woman visits, well baby visits, immunizations, and annual physicals per USPSTF guidelines.

3. Premium Plan

(In-Network Providers/Facilities ONLY)

- Plan has no deductible.
- Requires co-payments for most covered

services.
- An out-of-pocket maximum of $1,000 per person, $2,000 per family.
- The benefits include co-payments for physician office visits.
- For hospital admissions, emergency room care and other medical services, participants are responsible for co-payments and 20% co-insurance out-of-pocket.

4. Prescription Drug Plan for Core, Plus & Premium Plans

The prescription drug plan is the same for all three plans. The prescription benefit is a 4-tier structure and participants are responsible for a percentage of the total drug cost. Typically, Tier 1 will include generic or very common drugs, Tier 2 will include preferred name brand drugs, Tier 3 will include non-preferred name brand drugs, and Tier 4 will include specialty drugs.

PRESCRIPTION DRUG PLAN

Tier	Example Cost	% EE Pays	EE Cost	% Health Plan Pays	Health Plan Cost
Tier 1	$30	10%	$3	90%	$27
Tier 2	$95	20%	$19	80%	$76
Tier 3	$200	35%	$70	65%	$130
Tier 4	$760	50%	$380	50%	$380

The prescription plan has a separate $1,000 out-of-pocket maximum per participant. Once the out-of-pocket maximum is met, the Plan pays 100% of a participant's covered prescriptions for the remainder of the calendar year.

New Value Plan

The Value Plan is new for 2008 and you will notice several differences in the plan design when compared to the Core, Plus and Premium Plans.
- The Plan deductibles are $1,500 per person, $3,000 per family which qualifies as a high deductible plan as outlined in the Internal Revenue Code.
- The Plan deductibles DO apply toward the out-of-pocket maximums, which is different from the Core or Plus Plans.
- Medical and prescription expenses are combined under this plan.
  - There is no separate cap or co-insurance for prescriptions.
  - The deductible is applied to both medical and prescription expenses.
- After the deductible has been met for the plan year, the plan pays co-insurance of 90% and the participant is responsible for 10% of eligible expenses.
- The co-insurance applies to all incurred medical and pharmacy covered services, whether at the pharmacy, physician's office, the emergency room, out-patient surgery, or hospital admissions.
- The maximum amount of co-insurance that you will pay on this plan is $5,000 per person or $10,000 per family. Remember, unlike the Core and Plus Plans, this amount includes your deductible.
- The plan pays preventative care services at 100% regardless of whether you have met your deductible or not. These services include, but are not limited to well woman visits, well baby visits, immunizations, and annual physicals based on USPSTF guidelines.
- This plan also includes the opportunity to open and contribute to a Health Savings Account (HSA).
- The City will make a $500 contribution to an HSA account for employees and retirees.
  - You must open and make a contribution to the HSA account.
  - You must also complete the Health Assessment (both retiree and spouse if enrolled) at www.myuhc.com prior to November 30, 2007.

Pre-Existing Condition Exclusion Clause

The plans exclude a pre-existing condition that exists prior to initial enrollment when you have gone without coverage for more than 62 days. Excluded are services for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period before your initial enrollment date. (Your initial enrollment date is your first day of coverage.) If you had a medical condition in the past, but have not received any medical advice, diagnosis, care, or treatment within the 6 months prior to your initial enrollment date in the plan, your old condition is not considered a pre-existing condition to which exclusion will be applied.

If you are enrolling in a City of Arlington medical plan for the first time and you have a pre-existing condition, you will need to provide United Healthcare a copy of all certificates of creditable coverage to verify your previous medical coverage. If you have experienced a break in coverage of 63 days or more, benefits will be excluded only for conditions that are determined to be pre-existing, and no benefits will be payable for that condition for the first 12 consecutive months of coverage. Coverage in a City of Arlington medical plan is subject to the above criteria any time you waive coverage for yourself and/or eligible family members and subsequently enroll.

Medicare Supplement Plans

In 2008, participants age 65 and over who wish to remain on a City of Arlington health plan must choose either a Medicare Advantage Plan which includes pharmacy coverage or an AARP Plan with or without an added pharmacy option.

Representatives from Secure Horizons and AARP will be at the annual open enrollment meetings to further explain these plan offerings. Please refer to the "What's New for 2008" section under Post-65 Enrollment Procedure to review the 2008 enrollment process.

Do not complete a Retiree Enrollment/Change Form if you are currently enrolled in the Secure Horizons or AARP Plan K and you are NOT making a change in plans for 2008!

2008 Pre-65 Monthly Retiree Rates (Retirement Date prior to 1/1/2008)

Note: Retirees and retiree spouses age 65 and over are not eligible for the VALUE, CORE, PLUS or PREMIUM plans.

United HealthCare VALUE PLAN

Monthly Rates 2008

Individuals Under Age 65	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$237.16	$69.75	$167.41
Retiree + Spouse	$526.51	$256.98	$269.53
Retiree + Child or Children	$462.47	$215.54	$246.93
Retiree + Family	$723.36	$384.35	$339.01
Spouse/Surviving Spouse Only	$289.35	$187.23	$102.12
Spouse/Surviving Spouse + Child or Children	$514.66	$333.02	$181.64
15-19 yrs			
Retiree Only	$237.16	$41.85	$195.31
Retiree + Spouse	$526.51	$212.06	$314.45
Retiree + Child or Children	$462.47	$174.39	$288.08
Retiree + Family	$723.36	$327.85	$395.51
Spouse/Surviving Spouse Only	$289.35	$170.21	$119.14
Spouse/Surviving Spouse + Child or Children	$514.66	$302.75	$211.91
20-24 yrs			
Retiree Only	$237.16	$13.95	$223.21
Retiree + Spouse	$526.51	$167.14	$359.37
Retiree + Child or Children	$462.47	$133.23	$329.24
Retiree + Family	$723.36	$271.35	$452.01
Spouse/Surviving Spouse Only	$289.35	$153.19	$136.16
Spouse/Surviving Spouse + Child or Children	$514.66	$272.47	$242.19
25-29 yrs			
Retiree Only	$237.16	$0.00	$237.16
Retiree + Spouse	$526.51	$122.22	$404.29
Retiree + Child or Children	$462.47	$92.08	$370.39
Retiree + Family	$723.36	$214.85	$508.51
Spouse/Surviving Spouse Only	$289.35	$136.17	$153.18
Spouse/Surviving Spouse + Child or Children	$514.66	$242.19	$272.47
30+ yrs			
Retiree Only	$237.16	$0.00	$237.16
Retiree + Spouse	$526.51	$77.29	$449.22
Retiree + Child or Children	$462.47	$50.92	$411.55
Retiree + Family	$723.36	$158.35	$565.01
Spouse/Surviving Spouse Only	$289.35	$119.14	$170.21
Spouse/Surviving Spouse + Child or Children	$514.66	$211.91	$302.75

United HealthCare CORE PLAN

Monthly Rates 2008

Individuals Under Age 65	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$279.01	$111.60	$167.41
Retiree + Spouse	$619.42	$349.89	$269.53
Retiree + Child or Children	$544.09	$297.16	$246.93
Retiree + Family	$851.01	$512.00	$339.01
Spouse/Surviving Spouse Only	$340.41	$238.29	$102.12
Spouse/Surviving Spouse + Child or Children	$605.49	$423.85	$181.64
15-19 yrs			
Retiree Only	$279.01	$83.70	$195.31
Retiree + Spouse	$619.42	$304.97	$314.45
Retiree + Child or Children	$544.09	$256.01	$288.08
Retiree + Family	$851.01	$455.50	$395.51
Spouse/Surviving Spouse Only	$340.41	$221.27	$119.14
Spouse/Surviving Spouse + Child or Children	$605.49	$393.58	$211.91
20-24 yrs			
Retiree Only	$279.01	$55.80	$223.21
Retiree + Spouse	$619.42	$260.05	$359.37
Retiree + Child or Children	$544.09	$214.85	$329.24
Retiree + Family	$851.01	$399.00	$452.01
Spouse/Surviving Spouse Only	$340.41	$204.25	$136.16
Spouse/Surviving Spouse + Child or Children	$605.49	$363.30	$242.19
25-29 yrs			
Retiree Only	$279.01	$27.90	$251.11
Retiree + Spouse	$619.42	$215.13	$404.29
Retiree + Child or Children	$544.09	$173.70	$370.39
Retiree + Family	$851.01	$342.50	$508.51
Spouse/Surviving Spouse Only	$340.41	$187.23	$153.18
Spouse/Surviving Spouse + Child or Children	$605.49	$333.02	$272.47
30+ yrs			
Retiree Only	$279.01	$0.00	$279.01
Retiree + Spouse	$619.42	$170.20	$449.22
Retiree + Child or Children	$544.09	$132.54	$411.55
Retiree + Family	$851.01	$286.00	$565.01
Spouse/Surviving Spouse Only	$340.41	$170.20	$170.21
Spouse/Surviving Spouse + Child or Children	$605.49	$302.74	$302.75

2008 Pre-65 Monthly Retiree Rates (Retirement Date prior to 1/1/2008)

Note: Retirees and retiree spouses age 65 and over are not eligible for the VALUE, CORE, PLUS or PREMIUM plans.

United HealthCare PLUS PLAN

Monthly Rates 2008

Individuals Under Age 65	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$322.37	$154.96	$167.41
Retiree + Spouse	$715.68	$446.15	$269.53
Retiree + Child or Children	$628.64	$381.71	$246.93
Retiree + Family	$983.26	$644.25	$339.01
Spouse/Surviving Spouse Only	$393.31	$291.19	$102.12
Spouse/Surviving Spouse + Child or Children	$699.57	$517.93	$181.64
15-19 yrs			
Retiree Only	$322.37	$127.06	$195.31
Retiree + Spouse	$715.68	$401.23	$314.45
Retiree + Child or Children	$628.64	$340.56	$288.08
Retiree + Family	$983.26	$587.75	$395.51
Spouse/Surviving Spouse Only	$393.31	$274.17	$119.14
Spouse/Surviving Spouse + Child or Children	$699.57	$487.66	$211.91
20-24 yrs			
Retiree Only	$322.37	$99.16	$223.21
Retiree + Spouse	$715.68	$356.31	$359.37
Retiree + Child or Children	$628.64	$299.40	$329.24
Retiree + Family	$983.26	$531.25	$452.01
Spouse/Surviving Spouse Only	$393.31	$257.15	$136.16
Spouse/Surviving Spouse + Child or Children	$699.57	$457.38	$242.19
25-29 yrs			
Retiree Only	$322.37	$71.26	$251.11
Retiree + Spouse	$715.68	$311.39	$404.29
Retiree + Child or Children	$628.64	$258.25	$370.39
Retiree + Family	$983.26	$474.75	$508.51
Spouse/Surviving Spouse Only	$393.31	$240.13	$153.18
Spouse/Surviving Spouse + Child or Children	$699.57	$427.10	$272.47
30+ yrs			
Retiree Only	$322.37	$43.36	$279.01
Retiree + Spouse	$715.68	$266.46	$449.22
Retiree + Child or Children	$628.64	$217.09	$411.55
Retiree + Family	$983.26	$418.25	$565.01
Spouse/Surviving Spouse Only	$393.31	$223.10	$170.21
Spouse/Surviving Spouse + Child or Children	$699.57	$396.82	$302.75

United HealthCare PREMIUM PLAN

Monthly Rates 2008

Individuals Under Age 65	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$505.02	$337.61	$167.41
Retiree + Spouse	$1,121.15	$851.62	$269.53
Retiree + Child or Children	$984.79	$737.86	$246.93
Retiree + Family	$1,540.32	$1,201.31	$339.01
Spouse/Surviving Spouse Only	$616.13	$514.01	$102.12
Spouse/Surviving Spouse + Child or Children	$1,095.90	$914.26	$181.64
15-19 yrs			
Retiree Only	$505.02	$309.71	$195.31
Retiree + Spouse	$1,121.15	$806.70	$314.45
Retiree + Child or Children	$984.79	$696.71	$288.08
Retiree + Family	$1,540.32	$1,144.81	$395.51
Spouse/Surviving Spouse Only	$616.13	$496.99	$119.14
Spouse/Surviving Spouse + Child or Children	$1,095.90	$883.99	$211.91
20-24 yrs			
Retiree Only	$505.02	$281.81	$223.21
Retiree + Spouse	$1,121.15	$761.78	$359.37
Retiree + Child or Children	$984.79	$655.55	$329.24
Retiree + Family	$1,540.32	$1,088.31	$452.01
Spouse/Surviving Spouse Only	$616.13	$479.97	$136.16
Spouse/Surviving Spouse + Child or Children	$1,095.90	$853.71	$242.19
25-29 yrs			
Retiree Only	$505.02	$253.91	$251.11
Retiree + Spouse	$1,121.15	$716.86	$404.29
Retiree + Child or Children	$984.79	$614.40	$370.39
Retiree + Family	$1,540.32	$1,031.81	$508.51
Spouse/Surviving Spouse Only	$616.13	$462.95	$153.18
Spouse/Surviving Spouse + Child or Children	$1,095.90	$823.43	$272.47
30+ yrs			
Retiree Only	$505.02	$226.01	$279.01
Retiree + Spouse	$1,121.15	$671.93	$449.22
Retiree + Child or Children	$984.79	$573.24	$411.55
Retiree + Family	$1,540.32	$975.31	$565.01
Spouse/Surviving Spouse Only	$616.13	$445.92	$170.21
Spouse/Surviving Spouse + Child or Children	$1,095.90	$793.15	$302.75

2008 Post-65 Monthly Retiree Rates (Retirement Date prior to 1/1/2008)
MEDICARE ADVANTAGE & PART D PHARMACY PLAN

SECURE HORIZONS MEDICARE ADVANTAGE PLAN

Individuals Age 65 and Over	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$174.99	$7.58	$167.41
Retiree + Spouse	$349.98	$80.45	$269.53
Spouse/Surviving Spouse Only	$174.99	$72.87	$102.12
15-19 yrs			
Retiree Only	$174.99	$0.00	$174.99
Retiree + Spouse	$349.98	$35.53	$314.45
Spouse/Surviving Spouse Only	$174.99	$55.85	$119.14
20-24 yrs			
Retiree Only	$174.99	$0.00	$174.99
Retiree + Spouse	$349.98	$0.00	$349.98
Spouse/Surviving Spouse Only	$174.99	$38.83	$136.16
25-29 yrs			
Retiree Only	$174.99	$0.00	$174.99
Retiree + Spouse	$349.98	$0.00	$349.98
Spouse/Surviving Spouse Only	$174.99	$21.81	$153.18
30+ yrs			
Retiree Only	$174.99	$0.00	$174.99
Retiree + Spouse	$349.98	$0.00	$349.98
Spouse/Surviving Spouse Only	$174.99	$4.78	$170.21

*UHC PART D PHARMACY PLAN

(Must also enroll in either AARP Plan K, F, or J.)

Individuals Age 65 and Over	Total Cost
10-14 yrs	
Retiree Only	$167.58
Retiree + Spouse	$335.16
Spouse/Surviving Spouse Only	$167.58
15-19 yrs	
Retiree Only	$167.58
Retiree + Spouse	$335.16
Spouse/Surviving Spouse Only	$167.58
20-24 yrs	
Retiree Only	$167.58
Retiree + Spouse	$335.16
Spouse/Surviving Spouse Only	$167.58
25-29 yrs	
Retiree Only	$167.58
Retiree + Spouse	$335.16
Spouse/Surviving Spouse Only	$167.58
30+ yrs	
Retiree Only	$167.58
Retiree + Spouse	$335.16
Spouse/Surviving Spouse Only	$167.58

*This UHC Medicare Part D plan is only available if you enroll in either the AARP Plan F, J or K sponsored by the City. This plan is not available as a stand-alone Medicare Part D plan. However, the cost is shown above so you may compare to other Part D plan costs.

2008 Post-65 Monthly Retiree Rates (Retirement Date prior to 1/1/2008)
MEDICARE SUPPLEMENTAL PLANS

*AARP PLAN K

Individuals Age 65 and Over	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$93.98	$0.00	$93.98
Retiree + Spouse	$187.96	$0.00	$187.96
Spouse/Surviving Spouse Only	$93.98	$0.00	$93.98
15-19 yrs			
Retiree Only	$93.98	$0.00	$93.98
Retiree + Spouse	$187.96	$0.00	$187.96
Spouse/Surviving Spouse Only	$93.98	$0.00	$93.98
20-24 yrs			
Retiree Only	$93.98	$0.00	$93.98
Retiree + Spouse	$187.96	$0.00	$187.96
Spouse/Surviving Spouse Only	$93.98	$0.00	$93.98
25-29 yrs			
Retiree Only	$93.98	$0.00	$93.98
Retiree + Spouse	$187.96	$0.00	$187.96
Spouse/Surviving Spouse Only	$93.98	$0.00	$93.98
30+ yrs			
Retiree Only	$93.98	$0.00	$93.98
Retiree + Spouse	$187.96	$0.00	$187.96
Spouse/Surviving Spouse Only	$93.98	$0.00	$93.98

*AARP PLAN K (WITH UHC PART D PHARMACY)

Individuals Age 65 and Over	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$261.56	$94.15	$167.41
Retiree + Spouse	$523.12	$253.59	$269.53
Spouse/Surviving Spouse Only	$261.56	$159.44	$102.12
15-19 yrs			
Retiree Only	$261.56	$66.25	$195.31
Retiree + Spouse	$523.12	$208.67	$314.45
Spouse/Surviving Spouse Only	$261.56	$142.42	$119.14
20-24 yrs			
Retiree Only	$261.56	$38.35	$223.21
Retiree + Spouse	$523.12	$163.75	$359.37
Spouse/Surviving Spouse Only	$261.56	$125.40	$136.16
25-29 yrs			
Retiree Only	$261.56	$10.45	$251.11
Retiree + Spouse	$523.12	$118.83	$404.29
Spouse/Surviving Spouse Only	$261.56	$108.38	$153.18
30+ yrs			
Retiree Only	$261.56	$0.00	$261.56
Retiree + Spouse	$523.12	$73.90	$449.22
Spouse/Surviving Spouse Only	$261.56	$91.35	$170.21

*AARP rates are subject to change the 1st of April each year. The above schedule reflects estimated rates January through December, 2008 for the state of Texas.

AARP Health Care Options Plans — you will be billed directly by AARP if enrolling, and a contribution is required from you, based on years of service. These rates are estimates only; AARP determines your rate.

2008 Post-65 Monthly Retiree Rates (Retirement Date prior to 1/1/2008)
MEDICARE SUPPLEMENTAL PLANS

*AARP PLAN F

Individuals Age 65 and Over	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$192.41	$25.00	$167.41
Retiree + Spouse	$384.82	$115.29	$269.53
Spouse/Surviving Spouse Only	$192.41	$90.29	$102.12
15-19 yrs			
Retiree Only	$192.41	$0.00	$192.41
Retiree + Spouse	$384.82	$70.37	$314.45
Spouse/Surviving Spouse Only	$192.41	$73.27	$119.14
20-24 yrs			
Retiree Only	$192.41	$0.00	$192.41
Retiree + Spouse	$384.82	$25.45	$359.37
Spouse/Surviving Spouse Only	$192.41	$56.25	$136.16
25-29 yrs			
Retiree Only	$192.41	$0.00	$192.41
Retiree + Spouse	$384.82	$0.00	$384.82
Spouse/Surviving Spouse Only	$192.41	$39.23	$153.18
30+ yrs			
Retiree Only	$192.41	$0.00	$192.41
Retiree + Spouse	$384.82	$0.00	$384.82
Spouse/Surviving Spouse Only	$192.41	$22.20	$170.21

*AARP PLAN F WITH UHC PART D PHARMACY

Individuals Age 65 and Over	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$359.99	$192.58	$167.41
Retiree + Spouse	$719.98	$450.45	$269.53
Spouse/Surviving Spouse Only	$359.99	$257.87	$102.12
15-19 yrs			
Retiree Only	$359.99	$164.68	$195.31
Retiree + Spouse	$719.98	$405.53	$314.45
Spouse/Surviving Spouse Only	$359.99	$240.85	$119.14
20-24 yrs			
Retiree Only	$359.99	$136.78	$223.21
Retiree + Spouse	$719.98	$360.61	$359.37
Spouse/Surviving Spouse Only	$359.99	$223.83	$136.16
25-29 yrs			
Retiree Only	$359.99	$108.88	$251.11
Retiree + Spouse	$719.98	$315.69	$404.29
Spouse/Surviving Spouse Only	$359.99	$206.81	$153.18
30+ yrs			
Retiree Only	$359.99	$80.98	$279.01
Retiree + Spouse	$719.98	$270.76	$449.22
Spouse/Surviving Spouse Only	$359.99	$189.78	$170.21

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AARP Health Care Options Plans — you will be billed directly by AARP if enrolling, and a contribution is required from you, based on years of service. These rates are estimates only; AARP determines your rate.

2008 Post-65 Monthly Retiree Rates (Retirement Date prior to 1/1/2008)
MEDICARE SUPPLEMENTAL PLANS

*AARP PLAN J

Individuals Age 65 and Over	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$197.93	$30.52	$167.41
Retiree + Spouse	$395.86	$126.33	$269.53
Spouse/Surviving Spouse Only	$197.93	$95.81	$102.12
15-19 yrs			
Retiree Only	$197.93	$2.62	$195.31
Retiree + Spouse	$395.86	$81.41	$314.45
Spouse/Surviving Spouse Only	$197.93	$78.79	$119.14
20-24 yrs			
Retiree Only	$197.93	$0.00	$197.93
Retiree + Spouse	$395.86	$36.49	$359.37
Spouse/Surviving Spouse Only	$197.93	$61.77	$136.16
25-29 yrs			
Retiree Only	$197.93	$0.00	$197.93
Retiree + Spouse	$395.86	$0.00	$395.86
Spouse/Surviving Spouse Only	$197.93	$44.75	$153.18
30+ yrs			
Retiree Only	$197.93	$0.00	$197.93
Retiree + Spouse	$395.86	$0.00	$395.86
Spouse/Surviving Spouse Only	$197.93	$27.72	$170.21

*AARP PLAN J WITH UHC PART D PHARMACY

Individuals Age 65 and Over	Total Cost	Retiree Cost	City Cost
10-14 yrs			
Retiree Only	$365.51	$198.10	$167.41
Retiree + Spouse	$731.02	$461.49	$269.53
Spouse/Surviving Spouse Only	$365.51	$263.39	$102.12
15-19 yrs			
Retiree Only	$365.51	$170.20	$195.31
Retiree + Spouse	$731.02	$416.57	$314.45
Spouse/Surviving Spouse Only	$365.51	$246.37	$119.14
20-24 yrs			
Retiree Only	$365.51	$142.30	$223.21
Retiree + Spouse	$731.02	$371.65	$359.37
Spouse/Surviving Spouse Only	$365.51	$229.35	$136.16
25-29 yrs			
Retiree Only	$365.51	$114.40	$251.11
Retiree + Spouse	$731.02	$326.73	$404.29
Spouse/Surviving Spouse Only	$365.51	$212.33	$153.18
30+ yrs			
Retiree Only	$365.51	$86.50	$279.01
Retiree + Spouse	$731.02	$281.80	$449.22
Spouse/Surviving Spouse Only	$365.51	$195.30	$170.21

*AARP rates are subject to change the 1st of April each year. The above schedule reflects estimated rates January through December, 2008 for the state of Texas.

AARP Health Care Options Plans — you will be billed directly by AARP if enrolling, and a contribution is required from you, based on years of service. These rates are estimates only; AARP determines your rate.

Medical Plans Comparison Chart

***ONLY IN-NETWORK COVERAGE PROVIDED UNDER THESE PLANS**

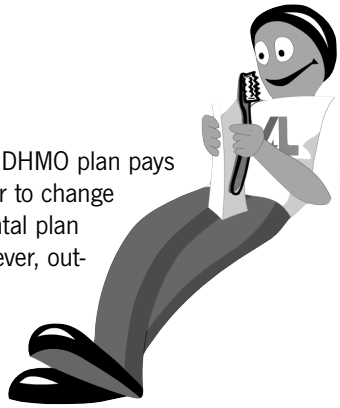
	Value Plan	Core Plan	Plus Plan	Premium Plan
Annual Deductible	$1,500/$3,000	$1,000/$2,000	$500/$1,000	None
Co-insurance	10% of eligible charges	20% of eligible charges	20% of eligible charges	20% of eligible charges (does not apply to phys. visits)
Co-insurance Out-Of-Pocket Maximum	$5,000/$10,000 Deductible applies to out-of-pocket	$4,000/$8,000 Deductible does not apply to out-of-pocket	$2,500/$5,000 Deductible does not apply to out-of-pocket	$1,000/$2,000 Deductible and co-pays do not apply to out-of-pocket
Physician Office Visit Specialist Office Visit After Hours Office Visit	10% after deductible 10% after deductible 10% after deductible	20% after deductible 20% after deductible 20% after deductible	20% after deductible 20% after deductible 20% after deductible	$25 co-pay $35 co-pay Differs by provider
Physical Exams Gyn Exams	10% after deductible 10% after deductible	20% after deductible 20% after deductible	20% after deductible 20% after deductible	$25 co-pay $25 co-pay if PCP, $35 if OB/GYN
In-Patient Hospital	10% after deductible	20% after deductible	20% after deductible	$200 co-pay per admission, then 20%
Emergency Room	10% after deductible	20% after deductible	20% after deductible	$100 co-pay per visit waived if admitted, then 20%
Urgent Care Facility	10% after deductible	20% after deductible	20% after deductible	$35 co-pay
Ambulance	10% after deductible	20% after deductible	20% after deductible	$50 co-pay, then 20% co-insurance
Outpatient Surgery	10% after deductible	20% after deductible	20% after deductible	Doctor's office: $25/35 co-pay. Outpatient facility: $150 co-pay, then 20%
Mental Health: Inpatient	10% after deductible	20% after deductible	20% after deductible	$200 co-pay per admission, then 20%
Outpatient	10% after deductible	20% after deductible	20% after deductible	$35 co-pay per visit
Radiology/Anesthesiology/ Pathology/Lab Services	10% after deductible	20% after deductible	20% after deductible	20% co-insurance
Pharmacy (local and mail order)	10% after deductible	See page 7. Tier plan with separate out-of-pocket maximum of $1,000 / individual.		

This comparison of benefits is only a summary to assist you in evaluating the different plans available to you and your family. A complete description of the services and benefits available is contained in the Summary Plan Description.

***NOTE: All out-of-network charges are your responsibility. Therefore, if you utilize an out-of-network provider or facility, you will be responsible for 100% of the charges.**

When considering the **Value, Core and Plus Plans,** it is important to remember that the participant is responsible for paying the deductible amount before any benefits will be paid toward medical care other than preventative care expenses.These services include, but are not limited to well baby/child care, well woman care, and annual physicals. By way of comparison, the **Premium Plan** covers eligible preventative care within the normal physician/specialist co-pay arrangement.

Dental Plans



The City's dental coverage is administered by United Healthcare. You may choose one of three dental plans. A DHMO plan pays benefits only when you use network providers located exclusively in Texas. To select a DHMO network dentist or to change your dentist, you must contact UHC. If you want more freedom in your dentist selections, we offer two PPO dental plan options. The PPO dental plans provide you with the freedom to choose any dentist, including specialists. However, out-of-pocket expenses are typically less when you select in-network providers.

DHMO Plan

The DHMO Plan has no deductible and is the lowest cost. However, when you are enrolled in the DHMO Plan, you must first be enrolled with a network dentist before scheduling appointments. All specialist referrals must be pre-approved by UHC and you may have to travel longer distances to obtain the care needed based on the location of an in-network specialist and appointment availability. You pay co-payments according to the plan's schedule. Co-payments vary depending on the services. There are no pre-existing condition exclusions and no annual maximums.

High PPO Plan

The High PPO Plan reimbursements are based on usual and customary (U&C) fees. Some dentists may charge more than the U&C rate, and you are responsible for charges that exceed the reimbursed rate. Benefits are subject to a $50 deductible for most services. There is an individual maximum benefit of $1,500 each year. Waiting periods for some services apply.

Low PPO Plan

The new Low PPO Plan reimbursements are based on a maximum allowable charge (MAC) fee schedule. Dentists may charge more than the MAC rate. Participants are responsible for charges that exceed the actual reimbursed rate. Benefits are subject to a $50 deductible for most services. There is an individual maximum benefit of $750 each year. Waiting periods for some services are required. Orthodontic care is not covered.

You will find additional information at www.myuhcdental.com, on the City's website and in the dental plan comparison chart below to assist you in selecting the plan that best fits your needs.

Dental Plan Cost
Cost per month

Coverage Level	DHMO	Low PPO	High PPO
Employee Only	$11.18	$11.78	$28.41
Employee + 1	$18.44	$23.34	$56.27
Employee + Family	$27.26	$41.08	$99.04

If you have relocated outside of Texas and want to obtain dental coverage through the City, you are only eligible to enroll in one of the PPO Dental plans.

Plan Feature	DHMO Plan (In-Network ONLY)	Low PPO Plan (In or Out-of-Network)	High PPO Plan (In or Out-of-Network)
Deductible (calendar year)	None	$50 per person/Maximum $150 ($50 x 3)	$50 per person/Maximum $150 ($50 x 3)
Preventative services: one visit every six months for a routine checkup, cleaning and polishing	Plan pays 100% after a $5.00 appointment co-pay and you must first be enrolled with a network provider.	Plan pays 80% of eligible dental fees. Deductible does not apply.	Plan pays 80% of eligible dental fees. Deductible does not apply.
Basic services: fillings, extractions, root canal therapy, scaling of teeth and basic oral surgery	You pay a fixed co-pay according to the plan's schedule and you must first be enrolled with a network provider.	Plan pays 60% of eligible dental fees after deductible met.	Plan pays 80% of eligible dental fees after deductible met
Major services: bridges, dentures, crowns, inlays, onlays, and complex oral surgery	You pay a fixed co-pay according to the plan's schedule and you must first be enrolled with a network provider.	Plan pays 50% of eligible dental fees after deductible met.	Plan pays 50% of eligible dental fees after deductible met.
Maximum annual benefit	No limit	$750 per person	$1,500 per person
Orthodontic care	See fee schedule (adults & children under age 25.)	No Coverage	50% with a lifetime maximum of $1,000 (children under 19 only.)
Waiting Period	None	12 months for major services	12 months for major services

Vision Plan

Vision coverage is available through Spectera. The plan pays benefits for annual exams and corrective lenses. You pay a co-pay for exams, and the plan pays benefits for frames and lenses up to certain limits. Under this plan, you may use in-network or out-of-network vision care providers. However, typically you receive greater benefits when you use in-network providers.

The plan will pay for contacts or eyeglass lenses once every 12 consecutive months and frames once every 24 consecutive months. A single co-pay covers either contacts or frames and/or eyeglass lenses.

Vision Plan Cost

Coverage Level	Monthly Cost
Retiree Only	$ 6.12
Retiree + 1	$ 12.85
Retiree + Family	$ 19.58

Plan Feature	In-network	Out-of-network
Comprehensive vision exam (once every 12 months)	$10 co-payment	Up to $40
Standard lenses (once every 12 months)	$10 co-payment (Each pair of lenses purchased through a participating Spectera provider includes scratch-resistant coating.)	Single vision lenses up to $40 Bifocals up to $60 Trifocals up to $80 Lenticulars up to $80
Contact lenses (in lieu of eyeglasses once every 12 months)	Up to four boxes (depending on prescription), fitting and two follow-up visits are covered in full after applicable co-pays.	Medically necessary up to $210 Elective up to $105
Standard frames (once every 24 months)	Most frames covered in full. May receive a $130 allowance on frames at retail chain providers. Contact Spectera for network providers in your area.	Up to $45 allowance
Refractive Eye Surgery	Discount at participating providers call 1.877.28-SIGHT.	No benefit

Flexible Spending Accounts (FSAs)

FSA

If you are eligible for the 2008 City contribution to the FSA, you may receive reimbursement for eligible health care expenses with these funds.

Through the FSA health account you are reimbursed for eligible health care expenses incurred by you, your spouse, and your eligible dependent children, regardless of whether they are covered by the City's medical, dental or vision plans, up to the full amount the City contributes for you in 2008.

FSA Grace Period and Claim Submission Deadline

On January 1, 2006, a grace period was implemented for incurring eligible expenses. This extension allows participants with an FSA account to continue to utilize any balance remaining as of December 31 each plan year, toward eligible expenses incurred from January 1 through March 15 during the next plan year. While this does not eliminate the use-it-or-lose-it rule completely, you now have additional time to access fund balances and avoid forfeiting these funds.

The deadline for submitting claims for eligible expenses has also been adjusted. You have until May 31 each plan year to submit claims for eligible expenses incurred from January 1 of one plan year through March 15 of the following plan year.

The deadline to submit claims for eligible expenses incurred in 2007 is May 31, 2008. Contributions not claimed by the deadline will be forfeited.

Eligible Expenses (See IRS Publication 502 for a complete list)

- Deductibles, co-payments, co-insurance or fees in excess of plan limits paid by the participant and not the health plan
- Vision expenses not covered by a plan, including exams, eyeglasses, contact lenses and solutions, optometrist and ophthalmologist fees and laser eye surgery
- Dental expenses not covered by a plan including cleanings, fillings and orthodontia
- Hearing aids
- Prescription drugs
- Diabetic supplies
- Specialized equipment for disabled persons
- Physical therapy, speech therapy, and psychotherapy
- Smoking cessation programs, including over-the-counter treatments
- Certain over-the-counter drugs such as:
    - Antacids and related drugs
    - Allergy and related drugs
    - Pain relievers

NOTE: You cannot claim an expense as a federal income tax deduction if it has been reimbursed through your FSA account.

Ineligible Expenses

Examples of expenses that are <u>not</u> eligible for reimbursement through your FSA health account are:

- Cosmetic expenses, toothpaste, toothbrushes and dental floss
- Face cream, moisturizers, suntan lotion, perfume, shampoos and soaps
- Vitamins
- Fees for exercise/athletic/health clubs
- Weight-loss programs for general health purposes

Health Savings Accounts (HSAs)

HSA

This year the City has added the Value Plan as an additional medical plan option which qualifies based on Internal Revenue Code as a high deductible plan. Enrollment in the City sponsored Value Plan provides you with the opportunity to open a Health Savings Account (HSA) with Exante Bank, a United HealthGroup Bank.

What are the Benefits of an HSA?

- You can claim a tax deduction for contributions you, or someone other than the City, make to your HSA even if you do not itemize your deductions on Form 1040
- Contributions to your HSA made by the City may be excluded from your gross income.
- The contributions remain in your account from year to year until you use them.
- The interest or other earnings on the assets in the account are tax free.
- Distributions may be tax free if you pay qualified medical expenses (See IRS Publication 969).

Do I Qualify for an HSA Account?

It is very important that you verify your eligibility to open an HSA account. Following are the guidelines as outlined In the Internal Revenue Code:

- Participant must be enrolled in the City's 2008 Value Plan on the first day of the month
- Participant cannot be covered by other health coverage (does not apply to specific injury insurance and accident, disability, dental care, vision care, and long term care)
- Participant cannot be claimed as a dependent on someone else's tax return
- Participant cannot be enrolled in Medicare

If you meet the following requirements, you are an eligible individual even if your spouse is enrolled in a non-high deductible plan (HDP) family coverage, provided your spouse's coverage does not cover you. You must then:

- Choose to open an HSA (minimum contribution level in 2008 is $10.00 per month)

- Choose Exante Bank as the exclusive HSA administrator (City of Arlington will pay the monthly administrative fees associated with the Exante Bank HSA while the participant is enrolled in the City's high deductible Value Plan)
- Take action to open an account ("affirm" intention to open account)

How Much May I Contribute to the HSA?

Contribution levels change each year. The 2008 contribution levels are:

- $2,900 individual
- $5,800 families

The City's contribution of $500 reduces the total amount a participant may contribute in 2008. The IRS also has a catch-up provision for those over age 55 of $900 in 2008.

Example: Retiree only coverage in Value Plan, completion of Health Assessment by November 30, 2007

- City contribution of $500
- Retiree elects maximum annual contribution of $2,900 - $500 = $2,400
- Retiree age 58 is allowed additional $900
- 2008 Monthly Contribution Amount for this example = $316.66

US Patriot Act Screening Process

The Patriot Act was created in 2001 in response to the 911 terrorism attacks to help the government fight the funding of terrorism and money laundering activities. Federal law requires all financial institutions to obtain, verify and record information that identifies each person who opens a bank account. The act requires banks to obtain and verify customers name, address, date of birth, and identification number (social security number) before allowing an account to accept contributions. All applicants requesting to open an HSA account must provide this information to Exante. Then Exante will notify the participant when the account has been approved and contributions may begin.

A secured database is maintained by Exante. The account belongs to the participant and all annual reporting is the responsibility of the participant. Account holders will be required to file Form 8889 with your 1040 annually. Exante provides monthly online statements at www.myuhc.com, an annual form 1099SA by January 31 each year, and an annual form 5498SA by May 31 each year.

Refer to the the City's website www.arlingtontx.gov, the IRS website www.irs.gov, IRS Publication 969, and/or your tax advisor for more HSA information.

HSA Qualified Expenses

Examples of qualified expenses include amounts paid for doctors' fees, prescription and non-prescription medicines, and necessary hospital services not paid for by insurance. Qualified medical expenses are those incurred by the following persons based on the most recent Publication 969 (2006):

- Yourself and your spouse
- All dependents you claim on your tax return
- Any person you could have claimed as a dependent on your return except that
  - The person filed a joint return
  - The person had gross income of $3,300 or more, or
  - You, or your spouse if filling jointly, could be claimed as a dependent on someone else's 2006 return.

May I Have an HSA and an FSA during the Same Year?

An individual covered by a high deductible plan and a health FSA that pays or reimburses qualified medical expenses generally cannot make contributions to an HSA. However, an individual can make contributions to an HSA while covered under a high deductible plan and a **limited purpose health FSA**. These arrangements can pay or reimburse specific items as outlined in IRS Publication 969. The listing includes dental care and vision care expenses. Therefore, if you have funds remaining in your FSA at the end of 2007, you will be eligible to enroll in the HSA and be reimbursed for dental or vision care expenses incurred from January 1 through March 15, 2008. (Refer to FSA section for claim filing deadlines – see page 17.)

Definitions

Annual Deductible: The deductible is the amount you must pay for covered health services based on contracted rates (also referred to as eligible charges/expenses) in a calendar year before the plan will begin paying benefits in that calendar year.

For example: The Value, Core and Plus Plans each have an annual deductible. When you access covered benefits (visit a physician, go to the ER, have surgery, etc.), you will pay the deductible first each year before being reimbursed for services. NOTE: In 2008 preventative care services are not subject to a deductible.

Annual Deductible for Family: The amount you must meet for covered family members before the plan will begin paying benefits in that calendar year.

For example: The individual deductible for the Core plan is $1,000; however, any time all family members reach a total of $2,000 toward the deductible, the annual deductible for the entire family is considered met. However, no more than $1,000 in eligible expenses is included from any one family member toward the $2,000 total family deductible.

Co-insurance: The portion of covered health care costs the covered person is financially responsible for, usually according to a fixed percentage.

Co-payment: The fixed charge you are required to pay for certain covered heath services. Some plans have co-payments which do not apply to the out-of-pocket maximum.

Covered Health Service(s): Those health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms. Refer to the Summary Plan Description (SPD) for a list of covered services. NOTE: The SPD currently located on the city website for the Core, Plus and Premium Plan include both covered and excluded services. The SPD for the Value plan will be added to the City website in 2008. The services included in all four of these plans are the same.

Information for the Secure Horizons and AARP plans may be found on their respective websites. Enrollees are also provided a paper copy of the SPD in the enrollment kits.

Dependent: An employee's legal spouse may be referred to as a dependent for benefit purposes. A dependent also includes unmarried children under the age of 25 that are eligible to be claimed as an IRS "qualifying child" (Refer to IRS Publication 501 at www.irs.gov) and the child must be either 1) your natural child, 2) a stepchild, 3) a legally adopted child, 4) a child placed for adoption, or 5) a child for whom legal guardianship has been awarded to the employee or the employee's spouse. Refer to page 5 of this guide for additional criteria.

Explanation of Benefits (EOB): A summary of the adjudication or processing of a claim. Once United Healthcare receives a claim for a medical encounter, it is processed and an EOB is created. You may view your EOBs on-line at www.myuhc.com. You must register to create a user name and password on myuhc.com to access your account. A summary of your EOB will be mailed to you each month in which a claim is processed. This statement outlines year-to-date deductible and out-of-pocket amounts met during the calendar year for all covered family members.

Initial Enrollment Period: The first 31 days of retirement or 31 days from a life event.

Life Event: Includes birth of a child, marriage, adoption, death, divorce and other changes that result in a gain or a loss of coverage as defined by IRS regulations. This includes a change in coverage due to a spouse's open enrollment period that does not coincide with the City's open enrollment period.

Out-of-Pocket Maximum: The maximum amount of co-insurance you pay every calendar year. Once you reach the out-of-pocket maximum, as an individual or family, benefits for those covered health services that apply to the out-of-pocket maximum are paid at 100% of eligible charges for the remainder of that calendar year. Deductibles and co-pays DO NOT apply to the out-of-pocket maximums for the Core, Plus, and Premium plans.

Pre-Existing Condition Exclusion: An injury or sickness that is identified as having been diagnosed or treated, or for which prescription medications or drugs were prescribed or taken, within the six month period ending on the person's enrollment date. (The enrollment date is the date the person became covered under the Plan.) A pre-existing condition does not include pregnancy. Genetic information is not an indicator, or a pre-existing condition, if there is no diagnosis of a condition related to the genetic information.

A certificate of creditable coverage may be provided to United Healthcare when a pre-existing condition claim has been received and other health coverage was in place within 63 days prior to the enrollment date for the Plan. The accepted method of documentation will be a certificate of creditable coverage from any group health plan (including COBRA continuation coverage), HMO, individual health insurance policy, Medicaid, or Medicare. The documentation accepted will include employer, third-party administrator of health plan, insurance carrier, or Centers for Medicare & Medicaid Services (CMS). Creditable coverage will be determined by the standard method.

A pre-existing condition exclusion may apply to a new hire or an employee or retiree who is returning to the City's medical plan after any period of no coverage for more than 62 days.

Primary Plan: The plan determined to be responsible for paying benefits first based on insurance contracts to include federal regulations such as Medicare and/or Medicaid. The Summary Plan Description (SPD) outlines coordination of benefit rules and CMS.

Secondary Plan: The plan determined to be responsible for paying benefits after a primary plan pays. Benefits may be reduced based on ineligible expenses to include

Medicare ineligible expenses, and/or requirements to satisfy plan provisions such as deductibles, co-pays, or co-insurance amounts. Typically does not pay or provide for 100% reimbursement of out-of-pocket expenses.

Summary Plan Description (SPD): Outline of eligibility, coverage, exclusions, coordination of benefit rules, schedule of benefits, claim and appeal process, and general information about the health plan. You may view a copy of the SPD on the City's website or obtain a copy from Workforce Services.

Supplemental Medicare Plan: A plan that supplements Medicare benefits based on eligible expenses.

Medicare Advantage Plan: An enhanced Medicare plan which covers more services and has lower out-of-pocket cost than the original Medicare plan. Some plans cover prescription drugs. In some plans, like Secure Horizons, you may only be able to see certain doctors or go to certain hospitals.

Retiree Benefit Payments

As a result of a growing retiree population and escalating healthcare costs, the City finds it necessary to establish guidelines regarding non-payment of benefit contributions as well as checks that have been returned by the bank that were submitted to the City for benefit payments.

Retirees are notified of the amount of their benefit premiums when they retire and each year prior to January 1. Benefit payments are due on the 1st of each month and must be paid in full on or before the due date. Payments may be made monthly, quarterly, or annually. If payments are not received in Finance by the 5th of the month, a 5% late fee will be imposed on each payment that is past due. A month's contribution and associated late fee must be paid in full no later than 60 days past the due date to avoid cancellation. If there are two payments past due, both month's premiums and associated late fees must be paid in full no later than 60 days past the first month's premium due date to avoid cancellation.

Benefit payments also become past due when a check that was sent in is returned by the bank. Returned checks will incur the City's returned check fee of $25. Payment must be made in full each month on the due date.

To ensure that retirees are given proper notification and ample opportunity to rectify a past due balance prior to cancellation, the following procedure is effective October 1,2007.

Retirees with past due premiums and associated late fees due to non-payment or returned checks will be subject to cancellation of their health, dental and vision benefits if premiums and associated late fees remain unpaid for 60 days.

Past Due 30 days – First Notice will be sent to retiree.

Past Due 45 days – Second Notice will be sent to retiree by certified mail.

Past Due 60 days – Cancellation Notice will be sent to retiree by certified mail.

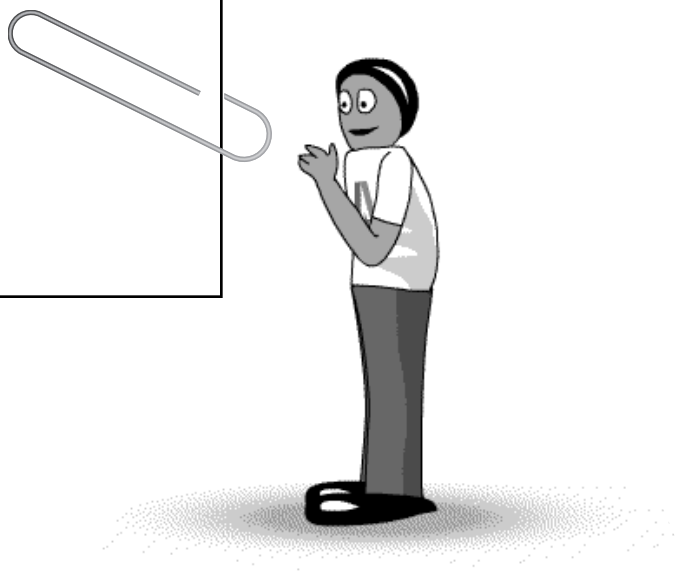
If all payments and/or late fees are not received in full within the 60 day timeframe, notice will be given to Workforce Services to process a cancellation of the retiree's benefit coverage. Retirees that have had their coverage cancelled will NOT be eligible to reinstate their benefits.

If you have any questions, please contact Jean House, Payroll/Accounts Payable Supervisor at 817-459-6308.

Retiree Personal Information Update!

It is the responsibility of all participants to notify the City of any changes in address, e-mail address and phone number. Please mail to:

City of Arlington
Workforce Services
PO Box 90231, MS 63-0790
Arlington, TX 76004-3231



General Notice—Continuation Coverage Rights Under COBRA

Introduction

You are receiving this notice because you have recently become covered under The City of Arlington Texas group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct.
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to The City of Arlington Texas, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: City of Arlington Texas, Attention: Workforce Services, 201 E. Abram – Suite 790, PO Box .90231, MS 63-0790, Arlington, TX 76004-3231. If the qualifying event is divorce or legal separation, please provide a copy of the executed decree as documentation of the date of the divorce or legal separation.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8

months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

There are two ways in which this 18-month period of COBRA continuation coverage may be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. Notice must be sent to: City of Arlington Texas, Attention: Workforce Services, 201 E. Abram – Suite 790, PO Box .90231, MS 63-0790, Arlington, TX 76004-3231. Please include a copy of your Social Security Determination letter.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may qualify for up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and dependent children receiving coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event occurred. In all of these cases, you must notify the Plan Administrator of the second qualifying event within 60 days of the second qualifying event. Notice must be sent to: City of Arlington Texas, Attention: Workforce Services, 201 E. Abram – Suite 790, PO Box .90231, MS 63-0790, Arlington, TX 76004-3231. Please include a copy of the death certificate, Medicare card(s) or divorce/legal separation decree as applicable.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage should be addressed to the contacts identified below. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office e of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

The Plan Administrator is City of Arlington Texas 817.459.6869. The Plan Administrator is responsible for administering COBRA continuation coverage. The City of Arlington, Texas has contracted with United Healthcare Directbill to administer COBRA continuation coverage. All COBRA elections are sent directly to UHC Directbill. Questions regarding COBRA elections and payments may be directed to UHC Directbill Customer Service 1.866.747.0048

Notes

Notes

Important Contacts

Workforce Services Department
Municipal Office Tower, Seventh Floor
201 E. Abram St., Suite 790 • Arlington, TX 76010 • 817-459-6869

Vendor/Plan	Member Service Phone Number	Hours of Operation	Web site
UnitedHealthcare (Medical)			**www.myuhc.com**
Customer Service	1-866-844-4864	6 a.m. - 6 p.m. (Monday-Friday)	
AARP HealthCare Options		7 a.m. - 11 p.m. (Monday-Friday)	**www.aarphealthcare.com**
Member Services	1-800-392-7537	9 a.m. - 5 p.m. (Saturday)	
Secure Horizons Medicare Advantage Plan		7 a.m. - 9 p.m.	**www.securehorizons.com**
Customer Service	1-800-950-9355	(Monday-Friday)	
UnitedMedicareRX			**www.UnitedMedicareRX.com**
Customer Service	1-888-556-6648	24 hours a day, 7 days a week	
UnitedHealthcare (Dental)			
National Pacific Dental DHMO	1-800-232-0990	7 a.m.-10 p.m. (Monday-Friday)	**www.nationalpacificdental.com**
UHC Dental Options PPO	1-877-816-3596	7 a.m.-10 p.m. (Monday-Friday)	**www.myuhcdental.com**
Spectera (Vision)			**www.spectera.com**
Customer Service	1-800-638-3120	7:30 a.m. - 7 p.m. (Monday-Friday) 8 a.m. - 4 p.m. (Saturday)	
UnitedHealthcare (Flexible Spending Accounts)			**www.myuhc.com**
Customer Service	1-877-311-7849	7 a.m. - 7 p.m. (Monday-Friday)	
Claim Submission Fax	1-915-781-1085		
UnitedHealthcare (Health Savings Accounts)			**www.myuhc.com**
Exante Bank	1-800-791-9361	8 a.m. - 6 p.m. CST	
UnitedHealthcare (Employee Assistance Plan - EAP)			**www.myuhc.com**
Care24 Customer Service	1-888-887-4114	24 hours	
Texas Municipal Retirement System (TMRS)			**www.tmrs.com**
Customer Service	1-800-924-8677	8 a.m. - 5 p.m.	

The 2008 Employee Benefit Guide
was produced especially for the retirees of the City of Arlington
by the Workforce Services Department.

ARLINGTON